ADHC Transition Planning Stakeholders Meeting
Responses to Questions
May 13, 2011

State Plan Amendment (SPA)	
1.	Is the proposed SPA eliminating ADHC as an optional Medi-Cal benefit available online or will it be sent to the stakeholder meeting participants? The SPA documents will be provided upon request.
2.	How long will it take for CMS to approve/reject the SPA? The proposed SPA was submitted to CMS on May 12, 2011. CMS has 90 days to approve the SPA or send a Request for Additional Information (RAI) to the State. If a RAI is submitted by CMS, then the State has 90 days to respond.
3.	In the SPA, the state is requesting an effective date of September 1. Does this mean that there will be no change before then? The proposed SPA was submitted to CMS on May 12, 2011. CMS has 90 days to approve the SPA or send a Request for Additional Information (RAI) to the State. There will be no change to the ADHC Medi-Cal benefit until CMS approves the SPA and the ADHC Medi-Cal benefit is eliminated. DHCS has requested September 1, 2011, as the proposed effective date of the elimination of ADHC as a Medi-Cal benefit. Once approval is received by CMS, then the effective date for the elimination is ". . . the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later." -- W&I Code, Section 14589.5(d).
4.	If CMS takes significant time to respond to the SPA and ADHCs remain operating during the next fiscal year, then will ADHC providers be reimbursed based on the current budget? ADHC providers will continue to be reimbursed by the Medi-Cal program until CMS approves the elimination of the ADHC Medi-Cal benefit and the effective date for the elimination is established.
5.	What happens if the federal government decides not to eliminate the benefit? The state requires CMS approval to eliminate the ADHC Medi-Cal benefit. If CMS denies the SPA, then the ADHC benefit will continue unless further legislative action is taken or DHCS successfully appeals CMS' denial of the SPA.
6.	What about the federal waiver? The waiver was contained in the legislative intent language. However, the legislature still needs to pass a bill and appropriate funding for the new waiver program to be developed.
7.	Has the federal government approved this shift in cost? No information regarding cost shifts has been discussed at this time.

Funding, Reimbursement, and Rates	
1.	The legislation allocated partial funding to ADHCs for the "new services." Will those funds be available to use to access services being transitioned to, and if so, how? If not, what will the allocated funds be used for? The May Revise allocated $25 million for the transition efforts. Final details have yet to be determined. The May Revise is available online at: http://www.ebudget.ca.gov/.
2.	Will the $85 million currently in the state budget for transition from ADHCs be used to purchase other services (e.g., if the participant transfers from ADHC to an ADP would the state reimburse for the ADP services)? The May Revise allocated $25 million for the transition efforts. Final details have yet to be determined. The May Revise is available online at: http://www.ebudget.ca.gov/.
3.	When do we start applying for “extent funding?” $25 million was allocated for the transition efforts, but the details of how this funding will be allocated have not been determined yet.
4.	How will we get paid during the transition period? Who will be paying? The proposed SPA was submitted to CMS on May 12, 2011. CMS has 90 days to approve the SPA or send a Request for Additional Information (RAI) to the State. There will be no change to the ADHC Medi-Cal benefit until CMS approves the SPA and the ADHC Medi-Cal benefit is eliminated.
5.	ADHC is not being eliminated -- the optional Medi-Cal benefit is. Please recognize in these discussions that the programs are not solely funded through Medi-Cal and will continue to exist as licensed programs. This comment is correct. AB 97 eliminated the optional ADHC Medi-Cal benefit and therefore ADHC centers will not receive funding from the Medi-Cal program.
6.	Will funds be available for participants to attend Adult Day Care Centers that are not ADHCs? Adult Day Care Centers is not a benefit under the Medi-Cal program.
7.	What about the cost of all the "transitional services" that will increase since the ADHCs are being asked to transfer participants to other services? How much will this cost the state? This cannot be determined at this time. It is uncertain as to how many and what services will be accessed.
8.	Is the proposed rate reduction on hold for now? The proposal for a 10% rate reduction requires federal approval via a State Plan Amendment.
9.	If there is no budget or waiver in place for ADHC for the next fiscal year, and if CMS does not approve the elimination in time, then where will the funding be coming from? The ADHC Medi-Cal benefit will continue as-is until CMS approves the elimination.
10.	Assembly Bill (AB) 97 mentioned a 10% reduction of Medi-Cal reimbursement for dates of service on and after June 1, 2011. Does the 10% reduction start on June 1, 2011? The effective date of the rate reduction is dependent on federal approval. The proposal for a 10% rate reduction requires federal approval via a State Plan Amendment.

Assistance and Transition to Other Services: Keeping Adults Free from Institutions (KAFI)

1. How does "KAFI" fit into the current discharge transition process?

   The KAFI program was contained in the legislative intent language. However, the legislature still needs to enact legislation and appropriate funding for a new program to be developed.

2. Is the transition program intended to be a provider of services until the KAFI program begins?

   The intention of the transition plan is to assist ADHC participants in accessing alternative services in the community.

3. Why is there no discussion regarding a "seamless transition" to the KAFI waiver program as has been previously discussed in legislative language?

   The KAFI program was contained in the legislative intent language. However, the legislature still needs to enact legislation and appropriate funding for a new program to be developed.

4. Will KAFI automatically start for the next fiscal year?

   No. The KAFI program was contained in the legislative intent language. However, the legislature still needs to enact legislation and appropriate funding for a new program to be developed.

5. Why wasn't KAFI approved before eliminating Medi-Cal as an optional benefit so that ADHCs could have a smoother transition?

   The KAFI program was contained in the legislative intent language. However, the legislature still needs to enact legislation and appropriate funding for a new program to be developed.

6. When will the proposed KAFI program be approved so that ADHCs can proceed to transition people with high acuity needs?

   The KAFI program was contained in the legislative intent language. However, the legislature still needs to enact legislation and appropriate funding for a new program to be developed.

7. Please provide more information about the federal waiver for the KAFI program for “very high acuity needs participants.” Per SB 73 and AB 1415, these measures pertaining to KAFI are an immediate priority.

   These bills have not been enacted. As stated previously, a funding appropriation has not been made by the legislature.

Assistance and Transition to Other Services: Non-KAFI Related

1. You mentioned that someone at DHCS would be assisting ADHC recipients with Treatment Authorization Requests (TARs) to enable them to obtain alternate services. Who would be assisting with such TARs?

   Southern California Medi-Cal Field Office staff will assist in reviewing Individual Plans of Care for those participants identified by ADHCs as needing further assistance in accessing services.

Assistance and Transition to Other Services: Non-KAFI Related (continued)
2. Will IHSS hours allow for meal preparation and shopping if the person lives with an informal unpaid caregiver who works? Who will be the care manager? DHCS will be coordinating with the California Department of Social Services (CDSS) on the need for assessment or reassessment of specific ADHC participants for IHSS hours. CDSS administers the IHSS program which is operated at the county level by social workers performing assessments for functional service needs. Needs may include assistance with meal preparation and shopping. To be an IHSS provider the informal unpaid caregiver (identified in this question) would need to be enrolled as an approved IHSS provider – providers can be a spouse, a parent, a relative or other individuals living in the home.
3. How will safety be ensured for those participants who will be more isolated daily by being cared for in their home as a result of this elimination? Assistance in accessing alternative community services will be offered during the transition.
4. What steps will be done to help with socialization, prevention of abuse and neglect and monitoring of vulnerable dementia clients who cannot report issues? Assistance in accessing alternative community services will be offered during the transition.
5. If there is not an agency or service that can meet the needs of our participants, then how long will we be able to provide service under our ADHC? This has yet to be determined.
6. On page 14 of the presentation, it states that the ADHC participant may continue to receive short-term transition-related therapy and treatment to the extent funding is allocated. Please explain the short-term transition. Why would it be short term? The short-term transition will take place until alternative services are arranged. $25 million is allocated for the transition, but no additional funding has been appropriated at this time.
7. It has clearly been identified by a number of knowledgeable speakers that the potential resources on your slides are not real options for transitioning ADHC participants to adequate care. Even SNF care will not be available to many of our participants, due to limited beds in our areas, behavioral issues, and the elimination of dementia units. Please speak to this. DHCS will be partnering with sister agencies such as the California Department of Aging, the Department of Social Services, and the Department of Mental Health to identify alternative services available for participants.
8. We have 50 participants that will go directly to nursing homes if we close. The remaining 150 or more will end up in SNFs weeks or months after that. There are no beds in any SNFs in the Santa Clara County. What are you planning to do with these folks? DHCS will be partnering with sister agencies such as the California Department of Agency, the Department of Social Services, and the Department of Mental Health to identify alternative services available for participants.

Assistance and Transition to Other Services: Non-KAFI Related (continued)	
9.	As a former hospice social worker in charge of nursing home participants, I know firsthand that in Contra Costa County nursing homes only set aside 5% of their beds for Medi-Cal patients. Since the eligibility requirements for ADHC participants is that they be at serious risk for institutionalization within 6 months, how do you expect to admit so many people into nursing homes when so few beds are available? DHCS will be partnering with sister agencies such as the California Department of Agency, the Department of Social Services, and the Department of Mental Health to identify alternative services available for participants.
10.	What are the services that were mentioned earlier in the meeting (pages 10 and 11) that will allow nursing care and supervision during the day? What is the closest service to offer nursing intervention and supervision during the day? Where can we discharge 60% of our participants to offer nursing intervention and supervision during the day? DHCS will be partnering with sister agencies such as the California Department of Agency, the Department of Social Services, and the Department of Mental Health to identify alternative services available for participants.
11.	For the staff-participant ratio, would core staff cover more participants in the future? If ADHC is eliminated as a Medi-Cal benefit, then Medi-Cal would have no authority in that decision.
Patient Discharge / Individual Plan of Care (IPC)	
1.	How long will we have before we will be forced to start discharging participants? Patient discharge will be dependent upon the facility's ability to continue to provide care for the participants once CMS (federal government) approval is obtained and an effective date for elimination of the ADHC Medi-Cal benefit is established.
2.	Who will review current IPCs and when? IPCs will be reviewed by staff at the ADHC centers and certain IPCs are currently being reviewed by DHCS.
3.	There will be discharges to nursing homes when ADHCs are no longer available as a Medi-Cal benefit. Are you ready to place those people? Do you have a number of available beds in nursing homes? Until there is an actual request to provide services in a nursing home, DHCS cannot predict if the number of available beds at that time will be adequate.
4.	Will the IPC review be done by DHCS or will it be internal to each ADHC? The IPC review will be a collaborative effort between the ADHC centers and DHCS staff.
5.	We have 240 participants who we are currently providing services for. Will there be additional reimbursement for completing their discharge plans since we would need additional manpower to provide the current services while also completing the discharge plans? Discharge planning is an integral part of the ADHC program and is included in the daily rate for ADHC.

Managed Care / Dual Eligibles
1. Is today's meeting only regarding the Medi-Cal participants and not the dual eligible participants? Medicare does not pay for ADHC, so Medi-Cal is currently paying for this service for dual eligible ADHC participants.
2. We currently have a participant who will have to enroll in managed care as of June 1, 2011. Will they still be eligible for ADHC services? Generally, the ADHC benefit is carved out of most managed care plans and is available through the participant's Medi-Cal Fee-For-Service coverage until such time as ADHC benefit is eliminated.
Timeline
1. Is the Department going to release a timeline about what was discussed at the stakeholders meeting? Do you have a timeline on when the transition from ADHC to KAFI will happen? The proposed SPA was submitted to CMS on May 12, 2011. CMS has 90 days to approve the SPA or send a Request for Additional Information (RAI) to the State. There will be no change to the ADHC Medi-Cal benefit until CMS approves the SPA and the ADHC Medi-Cal benefit is eliminated. DHCS has requested September 1, 2011, as the proposed effective date of the elimination of ADHC as a Medi-Cal benefit. Once approval is received by CMS, then the effective date for the elimination is ". . . the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later." -- W&I Code, Section 14589.5(d). The KAFI program was contained in the legislative intent language. However, the legislature still needs to enact legislation and appropriate funding for a new program to be developed.
2. What is the timeline for the cuts? The proposed SPA was submitted to CMS on May 12, 2011. CMS has 90 days to approve the SPA or send a Request for Additional Information (RAI) to the State. There will be no change to the ADHC Medi-Cal benefit until CMS approves the SPA and the ADHC Medi-Cal benefit is eliminated. DHCS has requested September 1, 2011, as the proposed effective date of the elimination of ADHC as a Medi-Cal benefit. Once approval is received by CMS, then the effective date for the elimination is ". . . the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later." -- W&I Code, Section 14589.5(d).
3. What is your timeline for the establishment of the transitional plans? With whom are you consulting in the development of the plans? What are the obstacles that exist as you make the plans? Discussions regarding the transition are currently being held between the various departments that can provide some type of an alternative service.
4. When is the target date for elimination of ADHC and stopping Medi-Cal payments? I am not sure the June date is practical for ADHC centers to stop operating and kicking the elderly out on street. The proposed SPA was submitted to CMS on May 12, 2011. CMS has 90 days to approve the SPA or send a Request for Additional Information (RAI) to the State. There will be no change to the ADHC Medi-Cal benefit until CMS approves the SPA and the ADHC Medi-Cal benefit is eliminated. DHCS has requested September 1, 2011, as the proposed effective date of the elimination of ADHC as a Medi-Cal benefit. Once approval is received by CMS, then the effective date for the elimination is ". . . the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later." -- W&I Code, Section 14589.5(d).

Timeline (continued)
5. How long is the gap between the ADHC closing and KAFI starting? Is it long- term as in months, or short-term as in weeks? The KAFI program was contained in the legislative intent language. However, the legislature still needs to enact legislation and appropriate funding for a new program to be developed.
Meeting Minutes and Materials
1. Would you please send the PowerPoint Presentation to the attendees? The PowerPoint Presentation is available online at: http://www.dhcs.ca.gov/Documents/ADHC%20Stakeholder%20Meeting%20Presentation%20for%205.13.11.pdf
2. Will the meeting minutes be available to the attendees? No. Written "minutes" were not taken, as the webinar audio was recorded.
Data
1. Will you be able to collect data on how many people this will have a severe impact on, including the supporting family members of the Adult Day Health Care participants? DHCS collects Medi-Cal beneficiary data from various sources.
2. The total number of participants was reported to be 27,000, which made the cost per participant $1050 per month. In reality, 35,000 participants make the cost per month only $760 (much less then IHSS cost per month). What was the purpose of giving the wrong information to the legislature when the right number of participants was always available through the MSSR report from the Department of Aging? The number of recipients with active TARs at that time has always averaged between 34,000 to 36,000.
3. What is the cost differential between supervised care IHSS as needed and your unplanned plan? IHSS is one of the alternatives for ADHC participants. DHCS is working with DSS to ensure participants can get an assessment / reassessment for IHSS hours.

Other Comments Received *	
1.	Many family members are not able physically, financially (they work) or emotionally to take on the role of what is provided at the ADHC. In these economic times families are losing services and support which are jeopardizing their economic welfare.
2.	You cannot serve this population per your plan as presented.
3.	Adult day health programs are crucial in providing respite for family caregivers and keeping someone with a chronic disease active and connected to his/her community and thus decreasing the risk of institutionalization. With fewer options in regards to long-term care, skilled nursing facilities become the alternative (and at a much higher price tag ultimately to the state). The state's decision to cut the optional benefit for ADHC was ill-conceived and short-sighted at best and inhumane at worst.
4.	Please consider as a part of your transition plan following up in some way to determine its effectiveness.
5.	In preparing for this presentation, it would have been helpful for you to have thought about who you were presenting to, the "stakeholders" or some could say the banner carriers. We consider ourselves partners with you in the delivery of health care services in our State and many have dedicated a good portion of their lives to this cause. Your presentation felt callous with absolutely no recognition of the value and benefits that these programs have provided to our participants, to the caregivers, to the state.
6.	It appears that DHCS is confused about where the services that are currently being offered by the ADHCs will be available and have not recognized that the ADHCs have been the "back bone" of preventing hospitalization/nursing home care. The services by the other Agencies are not available and will be more costly to the State of California in the long run and if ADHCs are forced to closed, then why should they care to reopen again with all the uncertainly? I would recommend since the DHCS made an error in the number of participants that they re-look at the folks that spoke today and work with them.
7.	How can the state legislative body take this action which is life-sustaining away from people who cannot speak out on their own behalf?
8.	I just want to add that MSSP case managers actually recommend ADHC services to their clients. With ADHC eliminated, MSSP case managers also lose one major resource that they can utilize. Therefore, sending discharged participants to MSSP is not realistic.
9.	There simply are no services that will "transition" most ADHC participants into a safe environment that meets their basic needs as well as meeting the needs of their caregivers to keep their loved ones out of needing a higher level of care. Everyone involved in decision making in this matter needs to go to an ADHC and witness for themselves the services provided for this vulnerable population.
10.	Have you realized that given the kind of services rendered by ADHCs compared to Home Health Agencies, the dollar amount paid to this agency is higher? ADHC are individualized and structured and yet all aspects of care are included and paid 76.27 per patient for at least 5 - 6 hours per day.

* These comments are provided so that all stakeholder feedback is acknowledged.